H.680

Introduced by Representatives Olson of Starksboro, Cole of Hartford, Garofano of Essex, Greer of Bennington, Keyser of Rutland City, Labor of Morgan, Masland of Thetford, McCann of Montpelier, and Yacovone of Morristown

Referred to Committee on

Date:

Subject: Health; health care professionals; primary care; Agency of Human Services; Green Mountain Care Board

Statement of purpose of bill as introduced: This bill proposes to establish a primary care access reform program in which participating primary care providers would receive a monthly payment from the patient's health insurer or other payer for each participating patient that would cover the patient's routine primary care services for the month without any cost-sharing requirements. The bill would require reports from the Agency of Human Services on expanding the program and from the Green Mountain Care Board on site-neutral reimbursements. The bill would also invest funds in primary care workforce development programs for fiscal year 2027 and eliminate the 2027 sunset on a primary care physician scholarship program.

An act relating to a primary care access reform program

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. FINDINGS; LEGISLATIVE INTENT

(a) The General Assembly finds that:

(1) Good access to primary care is essential for the health of Vermonters and for reducing the need for more costly services, but Vermont's health care system currently does not provide access to primary care with the timeliness and scope that Vermonters need. This lack of access pushes patients to seek traditional primary care services from specialists, urgent care clinics, emergency departments, pharmacies, out-of-state telehealth platforms, and other sources, further fragmenting care, reducing the professional satisfaction of primary care clinicians, and undermining patient trust in the primary care medical system.

(2) Primary care clinicians and patients face significant system-imposed administrative and cost burdens that delay or restrict provision of and access to high-value primary care. In addition, primary care clinicians are not compensated commensurate with their value to the health care system. As a result, many primary care clinicians are leaving their Vermont practices, and too few new clinicians are replacing them. Other clinicians are choosing a concierge or direct-care practice model in an effort to restore the focus on the patient-provider relationship and to avoid some of the cumbersome barriers in the health care system. While these models offer significant benefits to both

patients and providers, the patient panel sizes are generally much smaller than in traditional practice models, so more such practices are needed to meet the State's overall primary care needs.

(3) Vermont's health care system is in a state of crisis. Premiums in the commercial health insurance markets are increasingly out of reach for individual Vermonters, their families, private employers, and public employers such as schools and State and local governments. Increasing support for our primary care system in service of improving access to primary and preventive services is Vermont's best opportunity for short- and long-term improvements to Vermont's health care system and to the health of Vermonters.

(4) Access reform for primary care must support the four key functions of primary care—first-contact access, comprehensiveness, coordination, and continuity—which are essential to meeting the goals of improved quality and reduced spending. The success of access reform is highly dependent on alignment across payers and is unlikely to work if only a small subset of a practice's patient population is included. Increased investment in primary care across public and private payers using value-based care models designed for primary care will contribute significantly to improving health, reducing inequities, reducing the per capita cost of care over time, and improving the well-being of the primary care team.

(5) A national time study revealed that during the office day, physicians spent 27.0 percent of their total time on direct clinical face time with patients and 49.2 percent of their time on electronic health records and desk work. A 2022 study found that primary care clinicians would need to work 26.7 hours per day to provide guideline-recommended primary care to the typical patient panel, including documentation and message management.

(6) In 2020, the Green Mountain Care Board and the Department of Vermont Health Access submitted a report to the General Assembly that calculated primary care spending, both across all payers and by payer type, as a proportion of health care spending. The report found that 10.2 percent of all health care spending was allocated to primary care, though investment varied by payer, with Medicare at 6.5 percent, Medicaid at 24.3 percent, and commercial health insurance at 9.2 percent.

(7) The Green Mountain Care Board and the Agency of Human Services already have experience calculating primary care spending using both a State-specific definition of primary care and the New England States Consortium Systems Organization's (NESCSO) definition. Vermont is required to set a primary care spending target for purposes of the federal AHEAD model and has already proposed using the NESCSO definition of primary care.

(b) By enacting this act, it is the intent of the General Assembly to invest in primary care by establishing a streamlined primary care payment system that

will promote the public good by increasing access to primary care in order to improve the health of Vermonters and reduce health care system costs.

Sec. 2. 18 V.S.A. § 721 is added to read:

§ 721. PRIMARY CARE ACCESS REFORM PROGRAM

(a)(1) The Agency of Human Services, in coordination with the Green Mountain Care Board, the Blueprint for Health, and the Vermont Steering Committee for Comprehensive Primary Health Care, and in consultation with other interested stakeholders, shall develop and implement a primary care access reform program that will promote the public good by investing in primary care and reducing administrative burdens in order to increase access to care and reduce health system costs.

(2) The primary care access reform program shall be voluntary for primary care practices and shall be funded by allocating a portion of commercial health insurance premiums; a portion of premium equivalents from other participating payers; and, to the extent permitted by federal law, waivers of federal law, and federal initiatives, public funds from Medicare and Medicaid.

(3) The program shall collect and aggregate payments from participating payers in order to provide a capitated, per-member per-month payment to each participating primary care practice to cover all of the routine primary care

needs of attributed patients who are covered by participating plans, without any patient cost-sharing requirements.

(b)(1) To the extent that the program includes any practice participation requirements, administrative or documentation requirements, or quality measurements, the Agency shall establish them in a manner that streamlines and reduces the administrative burdens on primary care practices imposed by the program and by public and private payers, including aligning with and incorporating necessary Blueprint for Health requirements.

(2) The program shall establish not more than 12 quality measures and may require a primary care practice to adopt not more than six of them. Each quality measure shall be claims-derived, patient-centered, appropriate for a primary care setting, and supported by peer-reviewed, evidence-based research indicating that the measure is actionable and that its use will lead to improvements in patient health.

(3) The program shall identify and reform administrative burdens and requirements imposed on primary care providers, including data collection requirements, data system coordination, increased uniformity of requirements across networks and payers, and electronic health records requirements.

(4) Practice participation requirements shall include reasonable access improvement standards, the goals of which are to make meaningful progress toward reducing the percentage of primary care practices that are not accepting

new patients and toward reducing the average wait times for appointments. The standards shall incorporate metrics for measuring progress in achieving these goals. Initiatives that practices may implement to meet the access improvement standards may include accepting walk-in patients, increasing the number of same-day appointments, adopting extended hours, and undertaking other appropriate access improvement efforts.

(c) The Agency shall adopt by rule a risk-adjusted allocation model for primary care practices participating in the access reform program that may be informed by previous accountable care organization payment methodologies and may blend base per-member per-month capitated payments with fee-for-service payments as needed for specific primary care services. The allocation shall include a reimbursement model and level that:

(1) accomplishes Vermont's primary care spending target as set forth in subsection (h) of this section;

(2) supports sufficient access to and sustainability of primary care services in Vermont;

(3) incorporates different methodologies as needed to address the unique needs of all practice types, including independent practices, federally qualified health centers and rural health centers, and hospital-based primary care practices;

(4) incorporates a methodology with the flexibility necessary to support and adjust for the different scope of services delivered by different practices;

(5) accounts for the closure of accountable care organizations;

(6) accurately attributes patients to primary care practices;

(7) is sufficient to support practices in offering comprehensive, team-based primary care that includes supports for mental health and social drivers of health; and

(8) to the extent permitted under federal law, does not require individuals covered by participating health plans to pay cost-sharing amounts when receiving routine primary care services from participating primary care providers and practices.

(d) The Agency shall operate a payment pool to:

(1) collect the primary care allocation of premiums, premium equivalents, and public program funds due from each payer; and

(2) determine the per capita payments or other payment mechanism to distribute the funds to participating primary care practices.

(e) The Agency of Human Services shall adopt rules in accordance with 3 V.S.A. chapter 25 to implement the primary care access reform program, including:

(1) determining the scope of the primary care services to be included in the capitated rate and the primary care practices that are eligible for participation in the program;

(2) if using, practice participation requirements, administrative and documentation requirements, and quality measurements, in accordance with subsection (b) of this section;

(3) the risk-adjusted allocation model, in accordance with subsection (c) of this section;

(4) operation of the payment pool, in accordance with subsection (d) of this section;

(5) program parameters that address and mitigate against practices avoiding high-risk patients or otherwise engaging in adverse selection, while also striving to maximize practice eligibility and participation;

(6) definitions of direct and indirect primary care spending and appropriate limits on indirect primary care spending as a percentage of health care spending, as set forth in subdivision (g)(2) of this section; and

(7) benchmarks for determining the program's performance, as set forth in subdivision (g)(3) of this section.

(f) The Agency of Human Services or the Green Mountain Care Board, or both, shall enter into negotiations with the Centers for Medicare and Medicaid Services in order to secure Medicare participation in the primary care access

reform program. The Agency or Board, or both, shall also conduct outreach to self-funded, nongovernmental employer-sponsored plans regarding opportunities for their voluntary participation in the program and to discuss with interested plans the appropriate allocation of premium equivalents to be paid into the payment pool, which amounts should not unfairly disadvantage individuals covered by fully insured plans, self-funded governmental plans, or public benefit programs.

(g)(1) Implementation of the primary care access reform program shall increase the proportion of total annual health care spending on behalf of Vermont residents that is spent on primary care, with an initial primary care spending allocation target of 15 percent of the total amount spent for all health care services delivered to Vermont residents both within and outside Vermont, to be met not later than January 1, 2029. The Agency shall establish a transitional schedule that increases the proportion of primary care spending over time in order to achieve the primary care spending target. The increased spending for primary care shall not result in an increase in the overall amount of health care spending for Vermont residents' care.

(2) The Agency shall limit indirect primary care spending, as defined by rule, as a percentage of total primary care spending for purposes of the primary care spending target.

(3) The Agency may establish a new, higher primary care spending target after the initial target has been achieved if the Agency's analysis determines that the primary care access reform program has met specific benchmarks established by the Agency by rule, in areas including access to primary care, quality of primary care services delivered, impact on health outcomes, and containment of overall health care costs.

(4) For purposes of the primary care spending allocation target, the Agency shall use a definition of primary care services that aligns with the definition used in the 2020 report determining the proportion of health care spending in Vermont that is allocated to primary care, which was submitted to the General Assembly by the Green Mountain Care Board and the Department of Vermont Health Access in accordance with 2019 Acts and Resolves No. 17, Sec. 2, and with the definition of primary care services used by the New England States Consortium Systems Organization (NESCSO).

(5)(A) Each health insurer with at least 5,000 covered lives under a health insurance plan issued, delivered, or issued for delivery in Vermont shall comply with the requirements of this subsection (g), including meeting or exceeding the annual primary care spending targets established pursuant to this subsection (g).

(B) In meeting its annual primary care spending obligations, each health insurer shall:

(i) ensure that the individuals covered by its fully insured plans do not bear a greater financial burden than their fair share of the expenses related to the insurer's compliance with its obligations under this subsection (g), with a proportional amount borne by individuals covered by noninsured plans administered by the insurer, if any; and

(ii) for nonprimary care services, adjust reimbursement rates, implement utilization management tools, and take other steps as needed to avoid increasing the health insurer's total health care spending, to the extent feasible and in accordance with rules and guidance adopted by the program.

(C) As used in this subdivision (5), "health insurer" has the same meaning as in section 9402 of this title.

(D) The Agency, in consultation with the Department of Financial Regulation and the Green Mountain Care Board, may adopt rules as appropriate to carry out the purposes of this subdivision (5).

Sec. 3. PRIMARY CARE ACCESS REFORM PROGRAM; IMPLEMENTATION DATE; REPORTS

(a) The Agency of Human Services shall begin operating the primary care access reform program established in Sec. 2 of this act on or before July 1, 2027.

(b) On or before December 15, 2026, the Agency of Human Services, in coordination with the Green Mountain Care Board, shall report to the House

Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee regarding:

(1) progress in establishing the primary care access reform program and a timeline for its implementation; and

(2) options for revenue sources and mechanisms, along with an operational and financial plan, for expanding the program not later than January 1, 2028, to any patient of a participating practice, regardless of type of the individual's health coverage or coverage status.

Sec. 4. VERMONT CLINICIAN LANDSCAPE; SITE-NEUTRAL REIMBURSEMENTS; REPORTS

On or before January 1, 2027, the Green Mountain Care Board shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare with:

(1) an updated version of the Board's 2017 Vermont Clinician Landscape Study report that reflects the current climate among practicing clinicians in Vermont; and

(2) an updated version of the Board's previous reporting regarding site-neutral reimbursements pursuant to 2015 Acts and Resolves No. 54, Sec. 23; 2016 Acts and Resolves No. 143, Sec. 5; and 2017 Acts and Resolves No. 85, Sec. E.345.1, including the current state of reimbursement differentials based on practice setting and ownership type, along with a description of any

significant efforts that have been implemented since 2017 toward achieving site-neutral reimbursements.

Sec. 5. INVESTMENTS IN PRIMARY CARE WORKFORCE

The sum of $6,750,000.00 is appropriated from the General Fund to the Department of Health in fiscal year 2027 for investments in the primary care workforce as follows:

(1) $1,250,000.00 for the first year of implementation of the Maple Mountain Family Medicine Residency Program, a new Teaching Health Center Graduate Medical Education Program that will increase the number of family medicine residents practicing in rural regions of Vermont. It is the intent of the General Assembly to appropriate funds in future fiscal years to allow for full implementation of the Program.

(2) $500,000.00 for the Medical Student Incentive Scholarship Program at the University of Vermont College of Medicine established pursuant to 18 V.S.A. § 33.

(3) $5,000,000.00 for the Vermont Educational Loan Repayment Program established pursuant to 18 V.S.A. § 32, to be used for loan repayment for physicians licensed pursuant to 26 V.S.A. chapter 23 or 33; naturopathic physicians licensed pursuant to 26 V.S.A. chapter 81; advanced practice registered nurses licensed pursuant to 26 V.S.A. chapter 28, subchapter 2; and physician assistants licensed pursuant to 26 V.S.A. chapter 31, who practice in

primary care, in order to fully fund existing demand for the Program using the number of applicants and the needs demonstrated when additional funding was made available through the American Rescue Plan Act, P. L. No. 117-2. It is the intent of the General Assembly to continue this investment annually until Vermont reaches an adequate supply of primary care clinicians relative to benchmarks.

Sec. 6. 2020 Acts and Resolves No. 155, Sec. 7a, as amended by 2021 Acts and Resolves No. 74, Sec. E.311.2, is further amended to read:

Sec. 7a. ~~SUNSET~~

~~18 V.S.A. § 33 (medical students; primary care) is repealed on July 1, 2027.~~

[Deleted.]

Sec. 7. EFFECTIVE DATES

This act shall take effect on passage, except that Sec. 5 (investments in primary care workforce) shall take effect on July 1, 2026.